National Gaucher Care Foundation

STATEMENT OF MEDICAL RECOMMENDATION

Patient Name:_____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: _____ Ethnic Origin: _____

Relatives diagnosed with Gaucher disease:

1. _____ 3. _____
2. _____ 4. _____

Relatives identified as carriers of Gaucher disease:

1. _____ 3. _____
2. _____ 4. _____

Current Clinical Symptoms

Symptoms of Gaucher disease first noticed: _____

Splenectomy: ❑ Yes ❑ No ❑ Partial Date: _____

Organomegaly: ❑ Liver size: _____ ❑ Spleen size: _____

Hematology: HGB_____ HCT _____

Platelet Count_____ ❑ Bleeding Tendency

Other: _____

Skeletal Involvement:_____

_____

Other: _____

_____

Physician Recommendation for Screening and/or Testing for Gaucher disease:

_____

Tests or Procedures Recommended:

_____

Physician Signature: _____ **Date:** _____

Physician Name (Print): _____

In lieu of this specific form, a signed physician's document indicating clinical symptomology, type and date of diagnostic testing preformed may be submitted.

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